

FAMILY ADVISORY COUNCIL APPLICATION

Children's Hospitals and Clinics of Minnesota

**Please contact the council if you have any questions or need this application in another form i.e. Language, Braille, or Spoken Word
Voicemail (612) 813-7696 Email: familyadvisorycouncil@childrensmn.org*

Today's date: _____

1. Your Name: _____

2. Home Address: _____

3. Phone Number: Daytime: _____ Evening: _____

4. Email Address: _____

* Beyond the work of the Family Advisory Council, Families as Partners can connect interested families with other opportunities for involvement at Children's. Length of commitment ranges from one-time events to on-going groups. Specific training provided as needed

Would you like the information you provide in this application to also be forwarded to the Families as Partners Program Yes No

5. Languages spoken in the home: _____

6. Occupation: _____

** New families who are recently bereaved are asked to wait two years after the death of their child before applying to the FAC **

7. Name of child with health needs/experiences (if more than one child please add under question #)

_____ Child's DOB: _____ Relation to you: _____

8. Child's Primary Diagnosis: _____

9. Other Children? Yes (please enter names and dates of birth) No

10. What Campus does your family primarily use: _____
Has your family used other Children's locations (check all that apply) Mpls St. Paul West
 Roseville Maple Grove Woodwinds

11. Would you be able to make a commitment to attend 2 hour monthly meetings for a term of three years? Yes No

12. Would you be able to make a commitment to join other committees and project work groups that are held on various dates and times?
 Yes No

If yes, what is your availability? Please indicate the hours you are available:

Day:	Monday	Tuesday	Wednesday	Thursday	Friday	Weekends
Daytime:						
Evening:						

Comments on Availability? _____

13. What services has your family used? (Check all that apply) Check **Past Year** if you have used this service within the past year or **Ever** if you have ever used this service.

Past Year	Ever		Past Year	Ever	
<input type="checkbox"/>	<input type="checkbox"/>	Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	Hematology/Oncology
<input type="checkbox"/>	<input type="checkbox"/>	Inpatient Unit _____	<input type="checkbox"/>	<input type="checkbox"/>	Home Care or Hospice
<input type="checkbox"/>	<input type="checkbox"/>	Neonatal ICU	<input type="checkbox"/>	<input type="checkbox"/>	Immunology
<input type="checkbox"/>	<input type="checkbox"/>	Pediatric ICU	<input type="checkbox"/>	<input type="checkbox"/>	Integrative Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Day/Outpatient Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Lab
<input type="checkbox"/>	<input type="checkbox"/>	Short Stay	<input type="checkbox"/>	<input type="checkbox"/>	Nephrology
<input type="checkbox"/>	<input type="checkbox"/>	Infant Care Center (ICC)	<input type="checkbox"/>	<input type="checkbox"/>	Neurology
<input type="checkbox"/>	<input type="checkbox"/>	Special Care Nursery	<input type="checkbox"/>	<input type="checkbox"/>	NICU follow up Clinic
Specialty Services:			<input type="checkbox"/>	<input type="checkbox"/>	Orthopedics
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Pain Team / Palliative Care
<input type="checkbox"/>	<input type="checkbox"/>	Audiology	<input type="checkbox"/>	<input type="checkbox"/>	Pharmacy
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatry
<input type="checkbox"/>	<input type="checkbox"/>	Birth center	<input type="checkbox"/>	<input type="checkbox"/>	Psychology
<input type="checkbox"/>	<input type="checkbox"/>	Cardiology	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory / Pulminology
<input type="checkbox"/>	<input type="checkbox"/>	Cath Lab	<input type="checkbox"/>	<input type="checkbox"/>	Radiology
<input type="checkbox"/>	<input type="checkbox"/>	Cleft/Craniofacial Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Lab / Clinic
<input type="checkbox"/>	<input type="checkbox"/>	Cystic Fibrosis Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Special Diagnostics
<input type="checkbox"/>	<input type="checkbox"/>	Developmental Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Surgery
<input type="checkbox"/>	<input type="checkbox"/>	Down Syndrome Clinic	<input type="checkbox"/>	<input type="checkbox"/>	TAMS/Adolescent Medicine
<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, and Throat	<input type="checkbox"/>	<input type="checkbox"/>	Urology
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy Clinic	Rehabilitation		
<input type="checkbox"/>	<input type="checkbox"/>	Feeding Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Gastroenterology/ GI	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	<input type="checkbox"/>	General Pediatric Clinic	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Therapy
<input type="checkbox"/>	<input type="checkbox"/>	Genetics			

14. Have you used the following Non-Medical Services? (Check all that apply)

<input type="checkbox"/> Family Resource Center	<input type="checkbox"/> Interpretive Services	<input type="checkbox"/> Children's Medical Organizer
<input type="checkbox"/> Financial Resources (MCARE)	<input type="checkbox"/> Ethics Consult	<input type="checkbox"/> Healing Quilt
<input type="checkbox"/> Sibling Play	<input type="checkbox"/> Social Work	<input type="checkbox"/> Caring Bridge Web Site
<input type="checkbox"/> Child Life	<input type="checkbox"/> Children's Web Page	<input type="checkbox"/> Chaplaincy
		<input type="checkbox"/> Other _____

15. What do you feel you could bring to the Family Advisory Council?

I acknowledge that I have provided accurate information to the best of my ability

Applicant Signature Date

Please send the completed application, HIPAA quiz, and MN State background check form to:

Family Advisory Council – Mail Stop #32-2120
Children's Hospitals and Clinics of Minnesota
2525 Chicago Ave South
Minneapolis, MN 55404